



Intermediate Care Facility Utilization Fee

Quarter ending ____/____/____

Federal ID # _____

Name and address of intermediate care facility

1. Total facility expenditures for quarter \$ _____
2. Line 1 times 5% (.05) \$ _____
3. Total number of resident bed days for quarter _____
4. Utilization fee per resident bed day
(line 2 divided by line 3) \$ _____
5. Total utilization fee due (line 3 times line 4) \$ _____
6. Penalty and interest \$ _____
7. Total paid with return \$ _____

Signature of preparer Date Phone

Prepare statement in duplicate, retaining a copy for your records. Statement and remittance for any tax due must be postmarked on or before the last day of the month following the end of each calendar quarter. If you have an questions, please call or write to:

Montana Department of Revenue/CVR
PO Box 5805
Helena, MT 59604-5805
(406) 444-6900